Case Number:	CM13-0017680		
Date Assigned:	10/11/2013	**Date of Injury:**	12/14/2010
Decision Date:	01/02/2014	**UR Denial Date:**	08/20/2013
Priority:	Standard	**Application Received:**	08/28/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The physician reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 12/14/2010. The primary diagnosis is carpal tunnel syndrome. This patient is a 51-year-old female whose occupation is a program technician who was injured due to carrying nail bins and also cumulative trauma from frequent typing. The patient has reported ongoing symptoms of left shoulder pain and left wrist and hand pain, cervical spine pain, and knee pain. Wrist MRI imaging has demonstrated no acute fracture. Electrodiagnostic testing has been reported to be consistent with carpal tunnel syndrome. Wrist MRI has also showed mild thinning of the triangular fibrocartilage without evidence of a right frank tear. A utilization review concluded that multiple topical medications were not supported by treatment guidelines. That review also concluded that a multi interferential stimulator was not supported by the guidelines as beneficial for carpal tunnel syndrome and that the use of this modality as an isolated form of treatment was not supported.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Fluriflex (Flurbiprofen 15%/ Cyclobenzaprine 10%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain-Topical Analgesics, Muscle Relaxants..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on topical analgesics state that the use of compounded agents, like the requested item, requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Additionally with reference to the component medication cyclobenzaprine, this guideline states there is no evidence for use of muscle relaxants as a topical product. For these reasons, the guidelines do not support the use of this topical agent. The request for FlurFlex topical cream is not medically necessary and appropriate.

TGHot (tramadol 8%/gabapentin 10%/menthol 2%/Camphor 2%/capsaicin .05%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain-Topical Analgesics-Gabapentin..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on topical analgesics states that the use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The medical records submitted for review do not provide such detail to support a rationale for this request. Additionally, regarding the component medication gabapentin, the same guideline states that gabapentin is not recommended. There is no peer-reviewed literature to support its use. Additionally, this same guideline does not support capsaicin at a concentration over 0.025%. For these reasons, this request is not medically necessary. The request for TGHot is not medically necessary and appropriate.

A multi interferential stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Stimulation Page(s): 118.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on interferential stimulation states the device is not recommended as an isolated intervention. This guideline suggests several situations where as an exception this treatment might be indicated including when pain is ineffectively controlled due to diminished effectiveness of medications or pain is ineffectively controlled with medications due to side effects or history of substance abuse. The records provided for review do not document such a rationale to support an indication interferential stimulation. For these reasons, the request for this device is not medically necessary. Additionally, it is not clear in the record if the multi interferential stimulator, as requested, refers to additional other forms of electrical stimulation. If so, the Chronic Pain Medical Treatment Guidelines do not address such multiple forms of electrical stimulation but

rather address each one individually. The request for a multi interferential stimulator is not medically necessary and appropriate.